DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 445013 B. WING 01/27/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2700 PARKWOOD AVE NHC HEALTHCARE, CHATTANOOGA CHATTANOOGA, TN 37404 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 038 K 038 SS=D NFPA 101 LIFE SAFETY CODE STANDARD K 038 Corrective Action: SS=D Exit access is arranged so that exits are readily 1. The delayed egress exit door next to accessible at all times in accordance with section room 225 has been repaired to release after fifteen(15) seconds of constant 7.1. 19.2.1 2/10/14 pressure. To be completed by: 2. The delayed egress doors located at the Patient Dining Room, Back Patio Door from Station 3. Stairway Door by room 428 and the Station 4 Front Hall stairwell will all This STANDARD is not met as evidenced by: 2/15/14 Based on testing and observations, it was be labeled with proper signage by: determined the facility failed to maintain the exits. The findings included: Identifying Other Patients / Areas: All other delayed earess exit doors. 1. Testing of the delayed egress exit door next to released appropriately. room 225 on 1/27/14 at 10:23 AM revealed that it 2. All other delayed egress exit doors had did not release after fifteen (15) seconds. The proper signage. magnetic lock did release upon alarm activation. Measure & Changes to be taken: 2. Observation on 1/27/14 at 10:43 AM revealed None other than corrective action. the following delayed egress doors were not detailed above. labled with the proper signage: Patient Dining Room, Back Patio door from Station 3, Stairway Monitoring Performance: door by room 428, and Station 4 front hall Administrator or designee will use a QA monitor that will be developed to check stairwel. delayed egress exit doors for proper These findings were verified by the maintenance release after 15 seconds of pressure and supervisor during the facility survey and that they have proper signage. The QA

This STANDARD is not met as evidenced by:

OTHER LSC DEFICIENCY NOT ON 2786

acknowledged by the administrator during the exit

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

monitor will be monthly for 2 months with

consisting of Medical Director or Physician

Designee, DON or Designee, ADM or Asst

members. After 2 months of monitoring, QA frequency may be reduced depending

results reported to the QA Committee

ADM, SW, Dietician and other team

on results. To be completed by:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Exception nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

K 130

Facility ID; TN3311

3/15/14

conference on 1/27/14.

NFPA 101 MISCELLANEOUS

K 130

SS=D

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM AP CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 09							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
445013		B. WING		01/27/2014			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 2700 PARKWOOD AVE		•	
NHC HEALTHCARE, CHATTANOOGA			CHATTANOOGA, TN 37404				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE į	(X5) COMPLETION DATE	
K 130	National Fire Protection Association 101 Life Safety Code 2000 Edition 8.2.3.2.4 Penetrations and Miscellaneous Openings in Fire Barriers. 8.2.3.2.4.2 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1)The space between the penetrating item and the fire barrier shall meet one of the following conditions: a.It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b.It shall be protected by an approved			K 130 SS=D Corrective Action: 1. The penetration in the fire barrier identified between the new and old to above the fire doors at the end of fire corridor at barrier from independent will be sealed and repaired by: Identifying Other Patients / Areas: 1. No other areas with penetrations identified during the survey observation. Measure & Changes to be taken: 1. None other than corrective action detailed above.	ouilding st floor living were tions.	2/10/14	
	device that is design (2)Where the put openetrate the fire solidly set in the between the item at of the following coalt shall be capable of maintain fire barrier. b. It shall be device that is design (3)Insulation and ducts shall not pass unless one of the fa. The mate maintaining the fire b. The mate approved device that specific purpose (4)Where design vibration into consideric personners.	ned for the specific purpose, enetrating item uses a sleeve barrier, the sleeve shall be a fire barrier, and the space and the sleeve shall meet one onditions: filled with a material that is ing the fire resistance of the protected by an approved and for the specific purpose, a coverings for pipes and a through the fire barrier collowing conditions is metical shall be capable of resistance of the fire barrier. Final shall be protected by an act is designed for the		Monitoring Performance: Administrator or designee will use a monitor that will be developed to che barrier walls for penetrations. The Committer walls for penetrations. The Committer walls reported to the QA Committer consisting of Medical Director or Phy Designee, DON or Designee, ADM of ADM, SW, Dietician and other team members. After 2 months of monito QA frequency may be reduced dependent on results. To be completed by:	eck fire QA s with se ysician or Asst	3/15/14	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 445013 8. WING 01/27/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2700 PARKWOOD AVE NHC HEALTHCARE, CHATTANOOGA CHATTANOOGA, TN 37404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) K 130 Continued From page 2 K 130 a.It shall be made on either side of the fire barrier. b.It shall be made by an approved device that is designed for the specific purpose. K 147 SS=D Based on observations, it was determined the Corrective Action: facility failed to maintain the fire barriers. 1. The computers located in front of electrical panels in vending & 2/15/14 The finding included: housekeeping areas will be relocated by: Observation on 1/27/14 at 11:35 AM revealed 2. The extension cords and power strips penetrations in the fire barriers in the following in use at computer desk in housekeeping locations: Wali between new and old building area, at the refrigerator next to Nurse above the fire doors and at the end of first floor Station 1, the business office and station 4 2/15/14 corridor at barrier from independent living. storage area will be removed by: This finding was verified by the maintenance Storage blocking electrical panels in the supervisor during the facility survey and Station 1 mechanical room, Station 2 acknowledged by the administrator during the exit mechanical room, Station 4 storage area conference on 1/27/14. and the electrical room in the laundry area 2/28/14 K 147 NFPA 101 LIFE SAFETY CODE STANDARD K 147 will be removed by: SS=D Electrical wiring and equipment is in accordance 4. The multiplug adapter in use in the with NFPA 70, National Electrical Code. 9.1.2 Station 2 day room will be removed by: 2/15/14 5. Electrical outlets within six (6) feet of the sink in the station 4 med room will be This STANDARD is not met as evidenced by: equipped with ground fault circuit Based on observations and testing, it was interrupters by: 2/15/14 determined the facility failed to maintain the electrical system. Identifying Other Patients / Areas: No other areas were identified during. The findings included: the survey.

 Observation on 1/27/14 at 10:10 AM revealed computers located in front of electrical panels in

the vending area and housekeeping areas.

(Continued on next page)

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 445013 B. WING 01/27/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2700 PARKWOOD AVE NHC HEALTHCARE, CHATTANOOGA CHATTANOOGA, TN 37404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLÉTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 147 Continued From page 3 K 147 2. Observation on 1/27/14 at 10:11 AM revealed an extension cord in use at computer desk in K 147 SS=D housekeeping area. Continued 3. Observation on 1/27/14 at 10:16 AM revealed Measure & Changes to be taken: back to back power strips at the refrigerator next Maintenance Staff will be inserviced on to nurse satin 1. the use of extension cords and power strips. To be completed by: 3/15/14 4. Observation on 1/27/14 at 10:20 AM revealed furniture storage, blocking electrical panels, in the Monitoring Performance: Station 1 mechanical room. Administrator or designee will use a QA monitor that will be developed to monitor 5. Observation on 1/27/14 at 10:30 AM revealed a the use of extension cords, access in front multiplug adapter without overcurrrent protection of electrical panels and excess storage in in use in the station 2 day room. mechanical rooms. The QA monitor will be monthly for 2 months with results 6. Observation on 1/27/14 at 10:34 AM revealed reported to the QA Committee consisting excess storage in the station 2 mechanical room. of Medical Director or Physician Designee, blocking the electrical panels. DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After Observation on 1/27/14 at 10:40 AM revealed a 2 months of monitoring, QA frequency may power strip plugged into an extension cord be reduced depending on results. To be plugged into a power strip in the business office. completed by: 3/15/14 8. Observation on 1/27/14 at 10:51 AM revealed storage blocking the electrical panel in the electrical room in the laundry area. 9. Observation on 1/27/14 at 10:53 AM revealed storage blocking the electrical panels in the station 3 electrical room. 10. Observation on 1/27/14 at 11:20 AM revealed the station 4 med room had electrical outlets

within six (6) feet of a sink and not equipped with

11. Observation on 1/27/14 at 11:23 AM revealed storage in front of electrical panels and back to

ground fault circuit interrupters.

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445013		(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		B. WING _		01/27/2014			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
NHC HEALTHCARE, CHATTANOOGA				2700 PARKWOOD AVE CHATTANOOGA, TN 37404			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	JLD BE COMPLETION		
K 147	back power strips in These findings were supervisor during the	the station 4 storage area. e verified by the maintenance be facility survey and be administrator during the exit	K 14	7 (Page Intentionally Blan	k)		
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